| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155637 | A. BUILDING 00<br>B. WING | 06/17/2011 |

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| F0000 | | F0000 | | |

This visit was for a Post Survey Revisit (PSR) to complaint number IN00090528 investigated on 5/19/11.

This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on 4/20/11 to the Recertification and State Licensure Survey completed on 2/23/11.

Complaint IN00090528 - Not corrected.

Survey dates: June 14, 15, and 17, 2011

Facility number: 001198
Provider number: 155637
AIM number: 100471000

Survey team:
Regina Sanders, RN-TC
Marcia Mital, RN
(June 15, 2011)
Sheila Sizemore, RN
(June 15, 2011)
Kelly Sizemore, RN
(June 15 and 17, 2011)

Census bed type:
SNF: 26
SNF/NF: 106

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Residential: 39<br>Total: 171<br><br>Census payor type:<br>Medicare: 28<br>Medicaid: 76<br>Other: 67<br>Total: 171<br><br>Sample: 14<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on June 20, 2011, by Bev Faulkner, RN | | | |
| F0282 SS=E | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on observation, record review, and interview, the facility failed to ensure physicians' orders and residents' plans of care were followed related to medication administration, skin tear interventions, and fall interventions for 5 of 14 residents reviewed for following residents' plans of care and physicians' orders in a total | F0282 | F0282 What is the corrective action taken for the resident found to be affected by the deficient practice? 1. Resident #C's MD was called 6/14/11 to clarify aricept order. The order was clarified to continue with Aricept 5 mg po qHS times four weeks and then increase dose to 10 mg po QHS for diagnosis of cognitive disorder.2. Resident #D's physician was notifed | 06/27/2011 |

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| | sample of 14 residents (Residents #B, #C, #D, #E, and #F)<br><br>Findings include:<br><br>1. Resident #C's record was reviewed on 06/14/11 at 2:35 p.m. The resident's diagnosis included, but was not limited to, dementia.<br><br>A Physician's order, dated 05/25/11, indicated an order for Aricept (cognition medication) 5 mg (milligrams) at bedtime for 30 days then increase the Aricept to 10 mg at bedtime.<br><br>A Medication Administration Record (MAR), dated 05/11, indicated the resident received the Aricept 5 mg at bedtime on May 26-31, 2011.<br><br>There was a lack of documentation on the MAR, dated 06/11, to indicate the resident had an order for Aricept 5 mg at bedtime. There was a lack of documentation on the MAR, dated 06/11, to indicate the resident received the Aricept as ordered by the physician.<br><br>During an observation of the Aricept medication card on 06/14/11 at 3:20 p.m., with LPN #3 present, the medication card indicated it had been delivered by the pharmacy on 05/25/11 and 30 tablets of | | 6/15/11 regarding condition of skin tear. Bactroban was discontinued and area open to air.3. Resident #B order for Bacitracin to right gluteal area was updated by physician 6/15/11 to discontinue Bacitractin to right gluteal area leave open to air. 4. Resident #E's physician was notified 6/17/11 and order was clarified to Voltaren apply 2 GM to each hand BID due to pain.5a. Resident F's care plan was updated 6/15/11 for resident to have nurse alarm in bed 5b. Resident #F a note written 6/17/11 in nurses notes that she is encouraged to wear geri sleeves and will wear for short period of time and remove. 6/20/11 note in nurses note states resident now refusing to have geri sleeves applied. Physician order 6/20/11 to discontinue geri sleeves.How will other residents having the potential to be affected by the same deficient practice be identifed and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. Whole house audit was conducted on 6/17/11 of all resident records.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?<br>The nurse management team will be trained on how to complete the end of month physician order, MAR, and TAR review process. | |

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| | Aricept had been delivered. The Aricept medication card indicated there were 15 tablets left in the card. (There should have been 20 tablets used if given every night).<br><br>During an interview on 06/14/11 at 3:20 p.m., LPN #3 indicated the Aricept order was not on the MAR. She indicated the Aricept had not been given as ordered.<br><br>2. Resident #D's record was reviewed on 06/15/11 at 10:55 a.m. The resident's diagnosis included, but was not limited to, dementia.<br><br>A Physician's order, 05/25/11, indicated an order for Bactroban (antimicrobial cream) to the resident's left shin wound daily until healed.<br><br>The TAR (Treatment Administration Record), dated 05/11, indicated the Bactroban treatment had been completed daily on May 25-30, 2011. The TAR indicated the Bactroban treatment had not been completed on 05/31/11 due to the resident being out of the building.<br><br>There was a lack of documentation on the TAR, dated 06/11, to indicate the resident had an order for the Bactroban treatment. There was a lack of documentation on the TAR, dated 06/11, to indicate the Bactroban treatment had been completed | | Only trained personnel will be allowed to complete this monthly process.<br>All licensed staff working the 11-7 shift will be educated on the nightly 24-hour physician order chart review guideline process. This process includes verifying that all new physician orders from the previous 24 hours have been placed on the Medication Administration Records and on the Treatment Administration Records as indicated.<br>All licensed staff will be educated on transfer order clarification and also the month end process that all new medication or treatment orders received after the Physician Order Sheets have been signed as reviewed through the end of month process have been transcribed to both the current month's MAR and/or TAR and the upcoming month's MAR and/or TAR. Nurse Managers will perform a double check of this each day during their clinical review process beginning on the 23rd of each month through the last day of the month to assure compliance.<br>All resident care plans have been reviewed and updated per resident assessment. A process has been established to communicate resident care plan needs to the CNA's on a daily basis.<br>Nursing staff will receive both directed education and facility provided education on following | |

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| | as ordered by the physician.<br><br>There was a lack of documentation in the resident's Physician's Orders and the Nurses' Notes, dated 05/25/11 to 06/15/11, to indicate the resident's left shin wound had healed or that the Bactroban had been discontinued.<br><br>During an observation of the resident's left shin wound with RN #4 on 06/15/11 at 12:50 p.m., the resident had a scabbed area on the left shin. The resident's wife was present during the observation and indicated the staff were no longer putting a treatment on the resident's shin.<br><br>During an interview on 06/15/11 at 1:15 p.m., RN #6 indicated the wound was not healed.<br><br>3. Resident #B's record was reviewed on 06/15/11 at 10:55 a.m. The resident's diagnosis included, but was not limited to, anemia.<br><br>A Physician's order, dated 05/17/11. indicated an order for Bacitracin (antibiotic ointment) daily to the resident's right gluteal (buttock) open area.<br><br>The TAR, dated 05/11, indicated the Bacitracin treatment had been completed as ordered 05/17/11 through 05/24/11. | | individualized resident care plans and physician orders.<br>What corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>Director of Nursing and Administrator will monitor compliance through random weekly audits including physician order and MAR/TAR comparison and care plan intervention implementation for 3 months and report findings to the QA committee. The facility's internal QA team has been provided a tool that will be updated with each change in a resident's plan of care to facilitate daily monitoring of care plan approach implementation. Daily rounds will be conducted utilizing this tool to assist with monitoring and continued compliance. | |

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| | The TAR indicated the Bacitracin treatment had been discontinued on 05/24/11.<br><br>There was a lack of documentation in the physician's orders, dated 05/17/11 through 06/15/11, to indicate the physician had discontinued the Bacitracin treatment.<br><br>The resident's TAR, dated 06/11, indicated the staff had completed the Bacitracin treatment on 06/01/11 through 06/14/11.<br><br>During an interview on 06/15/11 at 11 a.m., RN #1 indicated she was unsure why the Bacitracin treatment had been discontinued on 05/24/11.<br><br>During an interview on 06/15/11 at 11:10 a.m., LPN #2 indicated she was using the Bacitracin on the resident's right gluteal area this month.<br><br>4. Resident E's record was reviewed on 6/15/11 at 10:05 a.m. Resident E's diagnoses included, but were not limited to, congestive heart failure, osteoarthritis, and osteomyelitis.<br><br>Resident E's hospital discharge orders, dated 5/4/11, indicated to continue Voltaren (a medication for arthritis) gel apply topically twice a day to bilateral hands. | | | |

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The resident's admission physician's orders, dated 5/4/11, indicated the Voltaren gel was to be applied to the resident's hands twice a day as needed for pain.

The MAR (Medication Administration Record), dated 5/11, indicated the Voltaren was to be applied as needed twice daily to the resident's hands and had not been administered at all for the month of May.

The resident's MAR, dated 6/11, indicated the Voltaren gel was administered twice a day on 6/1/11 at 6 a.m. and 6 p.m. The MAR then indicated "rewritten 6/1/11." The MAR then indicated the Voltaren was to be applied to the resident's hands as needed. This was also yellowed out as discontinued. There was a lack of any further documentation on the MAR or the resident's TAR (Treatment Administration Record) of the Voltaren being applied to the resident's hands.

During an interview on 6/15/11 at 12:55 p.m., RN #1 indicated the hospital discharge orders should have been followed. She indicated the hospital orders take precedence and the nurse goes through the orders with the resident's physician. She indicated the Voltaren

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should have been applied twice a day. She indicated she did not know why the order had been discontinued on the MAR for June.

5. Resident F's record was reviewed on 6/15/11 at 10:09 a.m. Resident F's diagnoses included, but were not limited to, senile dementia, anxiety, and stroke.

A quarterly MDS (Minimum Data Set) assessment, dated 05/03/11, indicated Resident F was moderately impaired in decision making. The quarterly MDS assessment indicated Resident F required extensive assistance of one staff for transfers.

A) A "Fall Risk" assessment, dated 5/30/11, indicated the resident was a high risk for falls, scoring 16, a score of 10 or higher places the resident at risk for falls.

A care plan for falls, dated 2/14/11, lacked documentation of a fall intervention for a bed alarm. The fall intervention added on 5/30/11 indicated "Re-educate staff on proper use of bed alarm."

A "Fall Management Program Note," dated 5/30/11, indicated "Resident was observed sitting on her room (sic) floor near doorway @ (at) 9:15 a.m. Per staff interview resident had been assisted to

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| | bed 15 min (minutes) prior. She had a low bed et (and) is believed to have crawled out as she stated 'just wanted to get out.' Resident has no injury. She was assisted to w/c (wheelchair). We will re-educate staff on proper use of alarm....Plan of action to prevent reoccurrence: Re-educate staff on proper use of bed alarm"<br><br>An observation on 6/15/11 at 9:50 a.m., indicated Resident F had a bed alarm on her bed.<br><br>During an interview on 6/15/11 at 10:58 a.m., RN #4 indicated "According to the report the resident did not have the alarm turned on." RN #4 indicated the CNAs are supposed to check the alarms to make sure the alarms are working.<br><br>B) Resident F was observed on 6/15/11 at 9:50 a.m., and 10:20 a.m., the resident was up in her wheelchair and did not have on her geri sleeves.<br><br>A physician's telephone order, dated 6/9/11 at 9:00 p.m., indicated "Monitor abrasion on R (right) upper (arrow pointing upwards) arm every shift until healed. Geri sleeves as tolerated d/t (due to) fragile skin."<br><br>During an interview on 6/15/11 at 10:20 | | | |

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| | a.m., CNA #5 indicated the resident should have had on her geri sleeves.<br><br>CNA #5 was observed on 6/15/11, applying Resident F's geri sleeves on at 10:25 a.m. Resident F allowed the CNA to apply the geri sleeves without problem.<br><br>This deficiency was cited on 05/19/11. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>This federal tag relates to Complaint IN00090528<br><br>3.1-35(g)(2) | | | |

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